SERFF Tracking Number:	*BNLI-126579196*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45394*
Company Tracking Number:	*BNL-2010-20*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*6-Pack Combo*		
Project Name/Number:	*6-Pack Combo/BNL-2010-20*		

Filing at a Glance

Company: Brokers National Life Assurance Company

Product Name: 6-Pack Combo	SERFF Tr Num: BNLI-126579196	State: Arkansas
TOI: H21 Health - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 45394
Sub-TOI: H21.000 Health - Other	Co Tr Num: BNL-2010-20	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Amy Irby, Mandi Rodriguez, Holly Harrison, Robin Salkowski	Disposition Date: 04/12/2010
	Date Submitted: 04/09/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: 6-Pack Combo	Status of Filing in Domicile:
Project Number: BNL-2010-20	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 04/12/2010	Explanation for Other Group Market Type:
	State Status Changed: 04/12/2010
Deemer Date:	Created By: Holly Harrison
Submitted By: Holly Harrison	Corresponding Filing Tracking Number:

Filing Description:

Re: Company: Brokers National Life Assurance Company
6-Pack Combo
NAIC #: 74900
FEIN #: 63-0483783
Project Number: BNL-2010-20

The following referenced forms are beiung submitted for your review and approval:

SERFF Tracking Number:	*BNLI-126579196*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45394*
Company Tracking Number:	*BNL-2010-20*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*6-Pack Combo*		
Project Name/Number:	*6-Pack Combo/BNL-2010-20*		

- 6-Pack Combo Application Form # COMBO-6(2004)A
- 6-Pack Combo Change Card Form # CW-COMBO-6(2004)A

Once approved, these forms will be used in conjunction with previously approved Dental, Vision, HIP, AD&D, Cancer and Individual Term Life Policies. These forms were previously approved May 5, 2004, however we have made the changes to comply with our recent Individual Term Life Filing, SERFF Tracking # BNLI-126255691.

Please note that the Disclosure form will always be given with the application, when Individual Term Life is sold. A statement was added to comply with Arkansas Rule and Regilation 60s8(C)(a).

If you have any questions, please contact me at 800-798-1125, extension 1404, or email me at holly@bnlac.com.

Sincerely,

Holly Harrison
Compliance Assistant

Company and Contact

Filing Contact Information

Holly Harrison, Compliance Assistant	holly@bnlac.com	
7010 Hwy 71 West, Suite 100	512-383-0220 [Phone] 1404 [Ext]	
Austin, TX 78735	512-383-8502 [FAX]	

Filing Company Information

Brokers National Life Assurance Company	CoCode: 74900	State of Domicile: Arkansas
7010 Hwy 71 West	Group Code:	Company Type:
Suite 100	Group Name:	State ID Number:
Austin, TX 78735	FEIN Number: 63-0483783	
(800) 798-1125 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	$ 50.00 per filing.

SERFF Tracking Number:	*BNLI-126579196*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45394*
Company Tracking Number:	*BNL-2010-20*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*6-Pack Combo*		
Project Name/Number:	*6-Pack Combo/BNL-2010-20*		
Per Company:	No		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Brokers National Life Assurance Company	$50.00	04/09/2010	35538479
Brokers National Life Assurance Company	$50.00	04/12/2010	35560075

SERFF Tracking Number:	*BNLI-126579196*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45394*
Company Tracking Number:	*BNL-2010-20*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*6-Pack Combo*		
Project Name/Number:	*6-Pack Combo/BNL-2010-20*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/12/2010	04/12/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Filing Fees	Note To Reviewer	Holly Harrison	04/12/2010	04/12/2010
Additional Filing Fee	Note To Filer	Rosalind Minor	04/09/2010	04/09/2010

SERFF Tracking Number:	*BNLI-126579196*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45394*
Company Tracking Number:	*BNL-2010-20*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*6-Pack Combo*		
Project Name/Number:	*6-Pack Combo/BNL-2010-20*		

Disposition

Disposition Date: 04/12/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*BNLI-126579196*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45394*
Company Tracking Number:	*BNL-2010-20*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*6-Pack Combo*		
Project Name/Number:	*6-Pack Combo/BNL-2010-20*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	6-Pack Combo Application	Approved-Closed	Yes
Form	6-Pack Combo Change Card	Approved-Closed	Yes

SERFF Tracking Number:	*BNLI-126579196*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45394*
Company Tracking Number:	*BNL-2010-20*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*6-Pack Combo*		
Project Name/Number:	*6-Pack Combo/BNL-2010-20*		

Note To Reviewer

Created By:

Holly Harrison on 04/12/2010 08:35 AM

Last Edited By:

Rosalind Minor

Submitted On:

04/12/2010 02:31 PM

Subject:

Filing Fees

Comments:

The additional $ 50.00 was submitted, please let me know if any additional information or changes are needed.

Thank you,

Holly Harrison

SERFF Tracking Number:	*BNLI-126579196*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45394*
Company Tracking Number:	*BNL-2010-20*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*6-Pack Combo*		
Project Name/Number:	*6-Pack Combo/BNL-2010-20*		

Note To Filer

Created By:
Rosalind Minor on 04/09/2010 02:59 PM
Last Edited By:
Rosalind Minor
Submitted On:
04/12/2010 02:31 PM
Subject:
Additional Filing Fee
Comments:

Our filing fees under Rule and Regulation 57 has been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of $100.00. Please submit an additional $50.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

SERFF Tracking Number:	*BNLI-126579196*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45394*
Company Tracking Number:	*BNL-2010-20*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*6-Pack Combo*		
Project Name/Number:	*6-Pack Combo/BNL-2010-20*		

Form Schedule

Lead Form Number: COMBO-6(2004)A

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/12/2010	COMBO-6(2004)A	Application/ Enrollment	6-Pack Combo Application Form	Initial			COMBO-6(2004)A.pdf
Approved-Closed 04/12/2010	CW-COMBO-6(2004)A	Application/ Enrollment	6-Pack Combo Change Card Form	Initial			CW-COMBO-6(2004)A.pdf

BROKERS NATIONAL LIFE ASSURANCE COMPANY
Domiciled in the State of Arkansas
Administrative Office: 7010 Hwy 71 West, Suite 100, Austin, Texas 78735
Phone: 512-383-0220

6-Pack Combo Application
Payroll Deduction

Division No.	Billing ID No.
Employer	Requested Effective Date / 01 /
Applicant Name	Social Security Number – –
Date of Birth / / Age	Sex ❒ M ❒ F Date of Hire / /
Home Address	City State Zip
Home Telephone ( ) –	E-mail

All benefits may not be available in all states. Check with our Administrative Office.

❒ GROUP DENTAL INSURANCE
Complete this section and Section A (if applicable)

Level of Coverage:
❒ Applicant Only
❒ Applicant & Spouse
❒ Applicant & Child(ren)
❒ Applicant & Family

Choose One:
❒ Plan A
❒ Plan B
❒ Basic Plus

Monthly Premium $ _____

❒ INDIVIDUAL HOSPITAL INDEMNITY INSURANCE
Complete this section, Section A (if applicable), B & C

Level of Coverage:
❒ Applicant Only
❒ Applicant & Spouse
❒ Applicant & Child(ren)
❒ Applicant & Family

Choose One:
❒ Plan A
❒ Plan B

Use with Advertisement Form # ADV-HIB&ADD(0598)AB

Monthly Premium $ _____

Home Office Use: Application # _____

❒ INDIVIDUAL CANCER INSURANCE
Complete this section, Section A (if applicable) & B

Level of Coverage:
❒ Applicant Only
❒ Applicant & Spouse
❒ Applicant & Child(ren)
❒ Applicant & Family

Amount of Coverage:
❒ $100 Daily Benefit
❒ $200 Daily Benefit

Rider (if applicable):
❒ Return of Premium Benefit

I hereby represent to the best of my knowledge, information and belief, no person to be insured under the policy is now or has ever been diagnosed as a victim of Cancer, Carcinoma, Sarcoma, Hodgkin's Disease, Leukemia, Lymphoma or Malignancy, except

(list person and condition): _____

_____ who is to be excluded from such coverage of this cancer hospitalization plan.

Monthly Premium $ _____

Home Office Use: Application # _____

❒ GROUP VISION INSURANCE
Complete this section and Section A (if applicable)

Level of Coverage:
❒ Applicant Only
❒ Applicant & Spouse
❒ Applicant & Child(ren)
❒ Applicant & Family

Choose One:
❒ Plan A
❒ Plan B

Vision Program is chosen by your Employer

Monthly Premium $ _____

❒ INDIVIDUAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
Complete this section, Section A (if applicable) & B

Level of Coverage:
❒ Applicant Only
❒ Applicant & Spouse
❒ Applicant & Child(ren)
❒ Applicant & Family

Choose One:
❒ $10,000
❒ $20,000
❒ $30,000
❒ $40,000
❒ $50,000

Child(ren) Maximum Coverage is $10,000 per Covered Child

Monthly Premium $ _____

❒ INDIVIDUAL PRD 10 YEAR TERM LIFE INSURANCE
Complete this section, Section A (if applicable), B & C

Level of Coverage:
❒ Applicant Only
❒ Applicant & Spouse
❒ Applicant & Child(ren)
❒ Applicant & Family

Child Rider (per child listed):
❒ One Unit ($2,500)
❒ Two Units ($5,000)

Amount of Insurance:
Applicant $ _____
Spouse $ _____

I acknowledge receipt of Fair Credit Reporting Act Notice and Notice Regarding Medical Information Bureau.

Monthly Premium $ _____

Home Office Use: Application # _____

TOTAL MONTHLY PREMIUM $

SECTION A – DEPENDENTS *(If applying for Dependent Coverage)*

Spouse Name | Social Security Number – –

Date of Birth / / | Sex ❒ M ❒ F

Child Name (your dependent child(ren) only)	*Date of Birth*	*Sex*	*Full-Time Student?*
1.	/ /	❒ M ❒ F	❒ Yes ❒ No
2.	/ /	❒ M ❒ F	❒ Yes ❒ No
3.	/ /	❒ M ❒ F	❒ Yes ❒ No
4.	/ /	❒ M ❒ F	❒ Yes ❒ No
5.	/ /	❒ M ❒ F	❒ Yes ❒ No
6.	/ /	❒ M ❒ F	❒ Yes ❒ No

Student verification required at the time of a dental and vision claim. Guardianship documentation is required for all eligible dependents.

(Reverse side of application MUST be COMPLETED & SIGNED)

SECTION B – BENEFICIARY

	Applicant's		*Spouse's*	
Beneficiary Name				
Relationship to the Insured and Age		Age		Age

Dependent children's beneficiary will be the primary insured.

Contingent Owner of Policy & Child Rider (if applicable)	Age
Contingent Owner's Relationship to Insured	

SECTION C – HOSPITAL INDEMNITY AND TERM LIFE QUESTIONS

Complete the following questions for all proposed insured(s)	*Applicant*	*Spouse*	*Child(ren)*
1. For the past 90 days, have you been performing normal activities and been actively at work full time at your regular occupation?	❒ Yes ❒ No	❒ Yes ❒ No	N/A
2. Have you smoked any cigarettes in the past twelve months?	❒ Yes ❒ No	❒ Yes ❒ No	❒ Yes ❒ No
3. Have you been positively diagnosed or treated by a member of the medical profession for an immune deficiency disorder, AIDS, ARC (AIDS-Related Complex) or been told test results indicate exposure to the AIDS virus?	❒ Yes ❒ No	❒ Yes ❒ No	❒ Yes ❒ No
4. In the past 3 years, have you been positively diagnosed or treated by a member of the medical profession for: a) Heart trouble, high blood pressure, kidney or liver disease, diabetes, cancer, or mental or nervous disorder? b) Alcohol or drug abuse or arrested for Driving Under the Influence?	❒ Yes ❒ No ❒ Yes ❒ No	❒ Yes ❒ No ❒ Yes ❒ No	❒ Yes ❒ No ❒ Yes ❒ No
5. Do you have any chronic illness or condition which requires periodic medical care or may require future surgery?	❒ Yes ❒ No	❒ Yes ❒ No	❒ Yes ❒ No

Applicant's Occupation/Duties

Spouse's Employer | Occupation/Duties

	Height	*Weight*	*Birth State*		*Height*	*Weight*	*Birth State*
Applicant				*Child #3*			
Spouse				*Child #4*			
Child #1				*Child #5*			
Child #2				*Child #6*			

Please explain any YES answers for questions 3-5:

It is understood and agreed that: 1. The application includes any other underwriting questionnaires required by the Company. 2. The statements in this application: a) Are to form the basis of any policy issued; and b) Are true and complete to the best of my knowledge and belief. 3. All agreements made by us must be signed by our President, Vice President, Secretary or Assistant Secretary; no agent can accept risks, modify policies or waive any rights or requirements of the Company. 4. The acceptance by the proposed insured of a policy issued on this application will constitute ratification of any changes made by the Company. 5. No insurance will be in force: a) Until the policy has been delivered and accepted during the continued insurability of the insured person(s); and b) Unless nothing has happened since the date of the application that would require a different answer to any question; and c) Until the full first premium is paid, at which time the policy will take effect on its date of issue.

I authorize any licensed physician, medical practitioner, clinic, hospital or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge of me or members of my family for whom insurance application is made on my health or their health, to give Brokers National Life Assurance Company, or its reinsurers, any such information. A photographic copy of this authorization shall be as valid as the original. This authorization will be valid for 6 months from the date below.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I authorize my employer to make the necessary deductions from my salary to pay the premiums to Brokers National Life Assurance Company. Such deductions shall continue until: 1. Termination of my employment, 2. Written notice of cancellation by me, or 3. Termination of the insurance plan(s). I represent that I am not presently disabled and I am performing all the duties of my occupation at least 30 hours per week.

Will this insurance replace any other insurance? ❒ No ❒ Yes Give Company Name & Policy # _____

Does the agent have knowledge this insurance will replace any other insurance? ❒ No ❒ Yes

If applying for Term Life Insurance, the undersigned applicant and agent certify that the applicant has received the Terminal Illness Accelerated Benefit Rider Disclosure Notice.

Dated at _____ _____ X _____
City ***State*** ***Date*** ***Applicant's Signature***

X _____ X _____
Witnessed by: Licensed Agent ***Spouse's Signature (if applicable)***

Writing Agent Name _____ Agent # _____

Splitting Agent Name (if applicable) _____ Agent # _____

For Home Office Use Only

Plan _____ State _____ FR# _____ EPSI# _____ WP _____ OE _____ Effective Date _____

Notes: 1 / 15

Alpha Checked _____

BROKERS NATIONAL LIFE ASSURANCE COMPANY
Domiciled in the State of Arkansas
Administrative Office: 7010 Hwy 71 West, Suite 100, Austin, Texas 78735
Phone: 512-383-0220

6-Pack Combo Change & Waiver Form

Division No.	Billing ID No.
Employer	Requested Effective Date / / (or the current Paid to Date)
Applicant Name	Social Security Number – –
Home Telephone ( ) –	E-mail

❒ Change of Name _____
Reason for Change ❒ Marriage – Date of Marriage _____ ❒ Other _____
❒ Change of Address _____ City _____ State _____ Zip _____
❒ Request to Change Beneficiary – *Complete Section B*

❒ GROUP DENTAL INSURANCE

❒ Cancel My Coverage
❒ Add Spouse ❒ Add Dependent Child(ren) – *Complete Section A*
❒ Cancel Spouse ❒ Cancel Dependent Child(ren) – *Complete Section A*

Dental Waiver – I have been given the opportunity to apply for Group Dental Insurance, BUT:
❒ Do not wish for coverage
❒ Am covered under spouse's dental plan

Applicant Signature X _____
Date _____

❒ INDIVIDUAL HOSPITAL INDEMNITY INSURANCE

❒ Cancel My Coverage
❒ Add Spouse ❒ Add Dependent Child(ren) – *Complete Section A*
❒ Cancel Spouse ❒ Cancel Dependent Child(ren) – *Complete Section A*

Home Office Use: Policy # _____

❒ INDIVIDUAL CANCER INSURANCE

❒ Cancel My Coverage
❒ Add Spouse ❒ Add Dependent Child(ren) – *Complete Section A*
❒ Cancel Spouse ❒ Cancel Dependent Child(ren) – *Complete Section A*
❒ Change Coverage Amount to:
❒ $100 Daily Benefit
❒ $200 Daily Benefit

I hereby represent to the best of my knowledge, information and belief, no person to be insured under the policy is now or has ever been diagnosed as a victim of Cancer, Carcinoma, Sarcoma, Hodgkin's Disease, Leukemia, Lymphoma or Malignancy, except **(list person and condition)**:

_____

who is to be excluded from such coverage of this cancer hospitalization plan.

Home Office Use: Policy # _____

❒ GROUP VISION INSURANCE

❒ Cancel My Coverage
❒ Add Spouse ❒ Cancel Spouse
❒ Add Dependent Child(ren) – *Complete Section A*
❒ Cancel Dependent Child(ren) – *Complete Section A*

❒ INDIVIDUAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

❒ Cancel My Coverage
❒ Add Spouse ❒ Cancel Spouse
❒ Add Dependent Child(ren) – *Complete Section A*
❒ Cancel Dependent Child(ren) – *Complete Section A*
❒ Change Coverage Amount to:
❒ $10,000 ❒ $30,000 ❒ $50,000
❒ $20,000 ❒ $40,000

Child(ren) Maximum Coverage is $10,000 per Covered Child.

❒ INDIVIDUAL PRD 10 YEAR TERM LIFE INSURANCE

❒ Cancel My Coverage
❒ Add Spouse ❒ Cancel Spouse
❒ Add Dependent Child(ren) – *Complete Section A*
❒ Cancel Dependent Child(ren) – *Complete Section A*
❒ Change Coverage Amount to:
If Increasing Coverage Amount, Complete Section C
Maximum coverage is $50,000
Applicant $ _____
Spouse $ _____
Child Rider (per listed child)
❒ One Unit ($2,500) ❒ Two Units ($5,000)

Home Office Use: Policy # _____

SECTION A – DEPENDENTS *(If applying for Dependent Coverage or canceling Dependent Coverage)*

Spouse Name	Social Security Number – –
Date of Birth / /	Sex ❒ M ❒ F

Child Name (your dependent child(ren) only)	*Date of Birth*	*Sex*	*Full-Time Student?*
1.	/ /	❒ M ❒ F	❒ Yes ❒ No
2.	/ /	❒ M ❒ F	❒ Yes ❒ No
3.	/ /	❒ M ❒ F	❒ Yes ❒ No
4.	/ /	❒ M ❒ F	❒ Yes ❒ No
5.	/ /	❒ M ❒ F	❒ Yes ❒ No
6.	/ /	❒ M ❒ F	❒ Yes ❒ No

Student verification required at the time of a dental and vision claim. Guardianship documentation is required for all eligible dependents.

(Reverse side MUST be COMPLETED (if applicable) & SIGNED)

THE REVERSE SIDE MUST BE SIGNED FOR ALL CHANGES

SECTION B – BENEFICIARY *(This will change the beneficiaries for all insurance coverages with our company.)*

	Applicant's		*Spouse's*	
Beneficiary Name				
Relationship to the Insured and Age		Age		Age
Contingent Beneficiary				
Relationship to the Insured and Age		Age		Age

Dependent children's beneficiary will be the primary insured.

Contingent Owner of Policy & Child Rider (if applicable)	Age
Contingent Owner's Relationship to Insured	

SECTION C – HOSPITAL INDEMNITY AND TERM LIFE QUESTIONS

Complete the following questions for all proposed insured(s)	*Applicant*	*Spouse*	*Child(ren)*
1. For the past 90 days, have you been performing normal activities and been actively at work full time at your regular occupation?	❒ Yes ❒ No	❒ Yes ❒ No	N/A
2. Have you smoked any cigarettes in the past twelve months?	❒ Yes ❒ No	❒ Yes ❒ No	❒ Yes ❒ No
3. Have you been positively diagnosed or treated by a member of the medical profession for an immune deficiency disorder, AIDS, ARC (AIDS-Related Complex) or been told test results indicate exposure to the AIDS virus?	❒ Yes ❒ No	❒ Yes ❒ No	❒ Yes ❒ No
4. In the past 3 years, have you been positively diagnosed or treated by a member of the medical profession for: a) Heart trouble, high blood pressure, kidney or liver disease, diabetes, cancer, or mental or nervous disorder? b) Alcohol or drug abuse or arrested for Driving Under the Influence?	❒ Yes ❒ No ❒ Yes ❒ No	❒ Yes ❒ No ❒ Yes ❒ No	❒ Yes ❒ No ❒ Yes ❒ No
5. Do you have any chronic illness or condition which requires periodic medical care or may require future surgery?	❒ Yes ❒ No	❒ Yes ❒ No	❒ Yes ❒ No

Applicant's Occupation/Duties

Spouse's Employer | Occupation/Duties

	Height	*Weight*	*Birth State*		*Height*	*Weight*	*Birth State*
Applicant				*Child #3*			
Spouse				*Child #4*			
Child #1				*Child #5*			
Child #2				*Child #6*			

Please explain any YES answers for questions 3-5:

It is understood and agreed that: 1. The change form includes any other underwriting questionnaires required by the Company. 2. The statements in this change form: a) Are to modify the base of any policy issued; and b) Are true and complete to the best of my knowledge and belief. 3. All agreements made by us must be signed by our President, Vice President, Secretary or Assistant Secretary; no agent can accept risks, modify policies or waive any rights or requirements of the Company. 4. The acceptance by the proposed insured of a change made to the policy using this change form will constitute ratification of any changes made by the Company. 5. No change in insurance coverage will be in force: a) Until the request is approved by the Company and accepted during the continued insurability of the insured person(s); and b) Unless nothing has happened since the date of the change form that would require a different answer to any question; and c) Until the premium is paid that includes the premiums for the changes made, at which time the policy changes will take effect on its date of issue.

I authorize any licensed physician, medical practitioner, clinic, hospital or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge of me or members of my family for whom insurance application is made on my health or their health, to give Brokers National Life Assurance Company, or its reinsurers, any such information. A photographic copy of this authorization shall be as valid as the original. This authorization will be valid for 6 months from the date below.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I authorize my employer to make the necessary deductions from my salary to pay the premiums to Brokers National Life Assurance Company. Such deductions shall continue until: 1. Termination of my employment, 2. Written notice of cancellation by me, or 3. Termination of the insurance plan(s). I represent that I am not presently disabled and I am performing all the duties of my occupation at least 30 hours per week.

X _____ _____
Applicant's Signature ***Date***

X _____ X _____
Witness ***Spouse's Signature (if applicable)***

For Home Office Use Only

Plan _____ State _____ FR# _____ EPSI# _____ WP _____ OE _____ Effective Date _____

Notes:

1 / 15

Alpha Checked _____

SERFF Tracking Number:	*BNLI-126579196*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45394*
Company Tracking Number:	*BNL-2010-20*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*6-Pack Combo*		
Project Name/Number:	*6-Pack Combo/BNL-2010-20*		

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	04/12/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	04/12/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	04/12/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	04/12/2010
Bypass Reason:	N/A		
Comments:			